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# MEDICAL ALERT

March 27, 2001

Dear Healthcare Provider:

SUBJECT: **Recent Increase in Syphilis Cases in Hawaii**

During the first two months of 2001, there have been four cases of early syphilis reported in Hawaii. There were three infectious primary cases reported along with one early latent case. This compares to only two cases being reported in all of 2000.

Hawaii has had a very low incidence rate of syphilis, 0.3 cases per 100,000 population, for the past seven years. If the present trend were to continue for the remainder of the year, we would expect 24 cases with an incidence rate of 2.0 per 100,000 population. The dominant characteristic of the present outbreak is that the three male cases are men who have sex with other men (MSM). One of the three males was HIV positive. These are the same dominant characteristics of recent outbreaks in Los Angeles, San Francisco, and Seattle. The possibility of syphilis re-emerging as a major health problem in Hawaii is a serious concern.

The Department of Health asks for your assistance in the prompt diagnosis, treatment, and reporting of any syphilis cases you may encounter. The Department of Health recommendations for the patient management and reporting of primary and secondary syphilis are outlined in the following pages.

We strongly advise that all patients diagnosed with syphilis or any sexually transmitted disease (STD) have serologic testing for HIV infection.

We appreciate your continued support in the prevention and control of STD in Hawaii. If you have any questions or need more information regarding this advisory, please call Roy Ohye or Venie Lee of the STD Prevention Program at (808) 733-9281.

Sincerely,

Philip Bruno

Philip Bruno, D.O., F.A.C.P., Chief
Communicable Disease Division

# Hawaii Department of Health
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## CLINICAL CATEGORIES

Consider **primary syphilis** in the differential diagnosis of patients presenting with a painless ulcerative lesion (chancre) in the mouth, genitals, perineum, or anus with or without regional lymphadenopathy.

**Secondary (disseminated) syphilis** classically presents 2 to 8 weeks after primary infection as a copper colored maculopapular rash widely distributed on the trunk, extremities, and particularly on the palms and soles. The primary chancre may or may not be present. Additional findings in secondary syphilis may commonly include alopecia; highly infectious mucous patches on the lips, oropharynx, and genitalia; condylomata lata; generalized lymphadenopathy (especially epitrochlear adenopathy); fever, arthralgias, malaise, anorexia, weight loss, pharyngitis, laryngitis, aseptic meningitis, and anterior uveitis.

**Latent syphilis** is the stage of the disease where there are no clinical manifestations of syphilis, but the specific treponemal serologic test for syphilis is positive. Latent syphilis acquired within the preceding year is referred to as early latent syphilis. All other cases of latent syphilis are either late latent syphilis or syphilis of unknown duration.

**Late (tertiary) syphilis** includes chronic neurosyphilis, cardiovascular syphilis, ophthalmologic lesions, or local gummatous lesions.

## DIAGNOSIS

The direct examination of mucocutaneous lesions for spirochetes by **darkfield analysis** (DFA) is the definitive method for diagnosing primary and secondary syphilis.

If DFA is not available, the presumptive diagnosis of syphilis can be established by the tandem use of two types of **serologic tests for syphilis**: 1) a positive nonspecific nontreponemal serologic screening test, 2) that is confirmed by a specific antitreponemal antibody test. The Venereal Disease Research Laboratory Test **(VDRL)**, or the rapid plasma regain **(RPR)** tests are the two commonly used nonspecific screening tests. The two commonly used confirmatory treponemal tests are the fluorescent treponemal antibody absorbed **(FTA-ABS)**, or the microhemagglutination assay for antibody to *T. pallidum* **(MHA-TP)**.

All patients diagnosed with syphilis should have HIV testing. If a patient is co-infected with syphilis and HIV, then an evaluation for possible neurosyphilis or syphilitic eye disease is recommended.

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**TREATMENT**

| Clinical Category | Treatment of Choice* | Patients Allergic to Penicillin† |
|---|---|---|
| Primary Syphilis, Secondary Syphilis, and Early Latent Syphilis | **Benzathine penicillin G** 2.4 million units IM in a single dose. | **Doxycycline** 100 mg orally twice a day for 2 weeks, or **Tetracycline** 500 mg orally four times a day for 2 weeks. |
| Late Latent Syphilis, or Syphilis of Unknown Duration | **Benzathine penicillin G** 2.4 million units IM every week for 3 weeks. | Same as above, but administer the antibiotic for 4 weeks. |
| Gummatous and Cardiovascular syphilis | Same as for late latent syphilis. | Same as for late latent syphilis. |
| Neurosyphilis | **Aqueous crystalline penicillin G** 18-24 million units a day, administered as 3-4 million units IV every 4 hours for 10-14 days. | **Penicillin desensitization** followed by aqueous crystalline penicillin G therapy. |
| Syphilis during pregnancy‡ | The penicillin regimen appropriate for the syphilis clinical category. | **Penicillin desensitization,** followed by penicillin therapy, and specialty expert consultation. |

* IM =intramuscular, IV = intravenous

† Penicillin desensitization is recommended for patients having true penicillin allergy and neurosyphilis along with consultation with an infectious diseases expert. Alternative therapy for neurosyphilis includes chloramphenical, doxycycline, or ceftriaxone for patients who have not had penicillin desensitization in conjunction with infectious disease specialty consultation. Penicillin skin testing may be helpful.

‡ Only penicillin is recommend for the treatment of syphilis during pregnancy. If the patient is penicillin allergic, penicillin desensitization is recommended. Tetracycline, doxycycline, and erythromycin are **not** recommended. Expert consultation is advised.

All sex or needle-sharing partners within the preceding three months for a primary syphilis case, six months for secondary syphilis, and one year for early latent syphilis should also be evaluated and treated presumptively for early syphilis. Long-term sex partners of patients with late syphilis should be evaluated clinically and serologically for syphilis and treated based upon the examination results.

**REPORTING**

Syphilis is a notifiable disease. Immediately notify the Sexually Transmitted Disease (STD) Prevention Program Office of any case of syphilis pending laboratory confirmation. The number to report any notifiable STD is (808) 733-9281.

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Disease Intervention Specialists (DIS) are available to assist in patient education and partner counseling and referral. For assistance, contact the DIS Supervisor at (808)-733-9281. For all cases of syphilis, a DIS will be contacting your patient to obtain additional information necessary for the public health investigation.

**COUNSELING**

We request that you routinely ask patients with primary or secondary syphilis, within the 3 months and six months, respectively, of diagnosis:

1. Name(s) and locating information of the patient's sex partner(s) for referral and medical management.

2. Where they or their sex partners have traveled.

As for any patient with an STD, counsel patients about the risks of unprotected sexual relations. Advise travelers about the recent syphilis outbreaks on the West Coast of the United States. Encourage all patients diagnosed with an STD to have testing for HIV infection.

**REFERENCE**

Centers for Disease Control and Prevention. *1998 Guidelines for Treatment of Sexually Transmitted Diseases.* MMWR. 1998; 47 (No. RR-1): 28-49.